U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 11 August 2006

In the Matter of:

D.S.,
Claimant

Case No.: 2004-BLA-6433

v.

TRI DEAN MINING, INC.,
Employer

LIBERTY MUTUAL INSURANCE COMPANY,
Carrier

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest

Appearances:

Mr. Ron Carson
Stone Mountain Health Services
St. Charles, Virginia
For the Claimant

Francesca Maggard, Esq.
Lewis & Lewis
Hazard, Kentucky
For the Employer

Donna Sonner, Esq.
Office of the Solicitor
Nashville, Tennessee
For the Director, OWCP

Before: Alice M. Craft
Administrative Law Judge

DECISION AND ORDER DENYING BENEFITS

This proceeding arises from a claim for benefits under the Black Lung Benefits Act, 30 U.S.C. § 901, *et seq*. The Act and implementing regulations, 20 CFR Parts 410, 718, 725, and 727, provide compensation and other benefits to living coal miners who are totally disabled due to pneumoconiosis and their dependents, and surviving dependents of coal miners whose death was due to pneumoconiosis. The Act and regulations define pneumoconiosis, commonly known as black lung disease, as a chronic dust disease of the lungs and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. 30 U.S.C. § 902(b); 20 CFR § 718.201 (2005). In this case, the Claimant alleges that he is totally disabled by pneumoconiosis.

I conducted a hearing on this claim on March 30, 2005, in Knoxville, Tennessee. All parties were afforded a full opportunity to present evidence and argument, as provided in the Rules of Practice and Procedure before the Office of Administrative Law Judges, 29 CFR Part 18 (2005). At the hearing, the Claimant was the only witness. Transcript ("Tr.") 13-32. Director's Exhibits ("DX") 1-45, Claimant's Exhibits ("CX") 1-5, and Employer's Exhibits ("EX") 1-3 were admitted into evidence without objection. Tr. 7-9.

In reaching my decision, I have reviewed and considered the entire record, including all exhibits, the testimony at hearing, and the arguments of the parties.

PROCEDURAL HISTORY

The Claimant filed his initial claim on March 2, 1994. DX 1. The claim was denied by the District Director of the Office of Workers' Compensation Programs ("OWCP") on August 24, 1994, on the grounds that the evidence did not show that the Claimant had pneumoconiosis, or that it was caused by coal mine work, or that the Claimant was totally disabled. The Claimant did not appeal that determination.

More than one year later, on August 13, 1997, the Claimant filed a duplicate claim. DX 2. The duplicate claim was denied by the District Director, OWCP, on January 30, 1998, because the Claimant failed to establish any element of entitlement. The Claimant requested modification of the Director's determination on April 10, 1998. The Director denied the Miner's request for modification on June 1, 1998. The Claimant did not appeal further.

The Claimant filed his current claim on June 17, 2002. DX 4. The District Director issued a proposed Decision and Order denying benefits on February 6, 2004. DX 39. The Claimant requested a hearing, and the claim was referred to the Office of Administrative Law Judges for hearing on June 17, 2004. DX 45.

APPLICABLE STANDARDS

This case relates to a "subsequent" claim filed on June 17, 2002. Because the claim at issue was filed after March 31, 1980, and after January 19, 2001, the effective date of the current regulations, the current regulations at 20 CFR Parts 718 and 725 apply. 20 CFR §§ 718.2 and 725.2 (2005). Pursuant to 20 CFR § 725.309(d) (2005), in order to establish that he is entitled to benefits, the Claimant must demonstrate that "one of the applicable conditions of entitlement …

has changed since the date upon which the order denying the prior claim became final" such that he now meets the requirements for entitlement to benefits under 20 CFR Part 718. In order to establish entitlement to benefits under Part 718, the Claimant must establish that he suffers from pneumoconiosis, that his pneumoconiosis arose out of his coal mine employment, and that his pneumoconiosis is totally disabling. 20 CFR §§ 718.1, 718.202, 718.203, 718.204, and 725.103 (2005). I must consider the new evidence and determine whether the Claimant has proved at least one of the elements of entitlement previously decided against him. If so, then I must consider whether all of the evidence establishes that he is entitled to benefits. *Sharondale Corp. v. Ross*, 42 F.3d 993 (6th Cir. 1994).

ISSUES

The issues contested by the Employer, or by the Employer and the Director, are:

1. Whether the Claimant has pneumoconiosis as defined by the Act and the regulations.

2. Whether his pneumoconiosis arose out of coal mine employment.

3. Whether he is totally disabled.

4. Whether his disability is due to pneumoconiosis.

5. Whether the evidence establishes that one of the applicable conditions of entitlement has changed pursuant to 20 CFR § 725.309 (2005).

DX 45; Tr. 5-6. The Employer also reserved its right to challenge the statute and regulations. DX 23, 45; Tr. 6. Although the Employer initially contested whether it was the Responsible Operator, it withdrew that issue at the hearing. Tr. 5.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Factual Background and the Claimant's Testimony

The Claimant testified at the hearing and he was deposed by the Employer on July 15, 2003. DX 9. His testimony was consistent on both occasions. At the hearing, he said that he was born in 1945. He was 59 years old at the time of the hearing. Tr. 13. He completed the tenth grade. DX 4. He has one dependent for purposes of augmentation, his wife, whom he married in 1995. DX 4. His children were 16 and 17 years old at the time of his deposition. DX 9 at 14.

The Claimant alleged, and the Director found, that he worked in the mines for 17 years. Tr. 14; DX 45. The Employer stipulated to the 15 years of coal mine employment during the period the Claimant worked there, from 1978 to 1992. Tr. 10, 14. The Claimant's allegation of 17 years is confirmed by documents in the file, including his employment history, affidavits, and Social Security earnings records. DX 6-8, 10. I find that he had 17 years of coal mine employment.

The Claimant stated that he was a cutting machine operator, shop foreman, bolt machine operator, and a uni-track operator. DX 6; Tr. 14-15. He spent 10 hours a day underground. Tr. 15. He stopped working in 1992 after a mine accident, because of problems with his hip and breathing. Tr. 17-18. He was being treated for his breathing by Dr. Bruton. Tr. 18-19. The Claimant testified that he never smoked tobacco. Tr. 19; DX 9. His medical records support this testimony. In addition to his lung and hip problems, he had an aortic valve replacement in 1997. Tr. 20. He said he would not be able to go back in the mines because of his medical conditions. Tr. 21-22.

The Claimant's last coal mine employment was in Tennessee. DX 5. Therefore, this claim is governed by the law of the Sixth Circuit. *Shupe v. Director, OWCP*, 12 B.L.R. 1-200, 1-202 (1989) (*en banc*).

Material Change in Conditions

In a subsequent claim, the threshold issue is whether one of the applicable conditions of entitlement has changed since the previous claim was denied. The Claimant's previous claim was finally denied by the District Director, OWCP, on June 1, 1998, because the Claimant had failed to establish any of the elements of entitlement, and the denial became final one year later. As will be discussed in more detail below, medical opinions now establish that the Claimant has pneumoconiosis This constitutes a material change in conditions.[1] Because the new evidence establishes that a material change in conditions has occurred, I must consider all of the evidence in the record in reaching my decision whether he is now entitled to benefits. Evidence admitted in the prior claim may be considered notwithstanding the limitations on the introduction of evidence contained in the current regulations at 20 CFR § 725.414 (2005). 20 CFR § 725.309 (d)(1) (2005). Moreover, no findings in the prior claim are binding, unless a party fails to contest an issue, or made a stipulation in a prior claim. 20 CFR § 725.309(d)(4) (2005).

Medical Evidence

Chest X-rays

Chest x-rays may reveal opacities in the lungs caused by pneumoconiosis and other diseases. Larger and more numerous opacities result in greater lung impairment. The following table summarizes the x-ray findings available in connection with the current claim.

[1] In *Grundy Mining Co. v. Director, OWCP [Flynn]*, 353 F.3d 467 (6th Cir. 2003), a multiple claim arising under the pre-amendment regulations at 20 C.F.R. § 725.309 (2000), the Court reiterated that its previous decision in *Sharondale Corp. v. Ross*, 42 F.3d 993 (6th Cir. 1994) requires that the ALJ resolve two specific issues prior to finding a "material change" in a miner's condition: (1) whether the miner has presented evidence generated since the prior denial establishing an element of entitlement previously adjudicated against him; and, (2) whether the newly submitted evidence differs "qualitatively" from evidence previously submitted. Specifically, the *Flynn* Court held that "miners whose claims are governed by this Circuit's precedents must do more than satisfy the strict terms of the one-element test, but must also demonstrate that this change rests upon a qualitatively different evidentiary record." *See also, Tennessee Consolidated Coal Co. v. Kirk*, 264 F.3d 602, 608-610 (6th Cir. 2001). Once a "material change" is found, then the ALJ must review the entire record *de novo* to determine ultimate entitlement to benefits. As the discussion below demonstrates, the record in the current claim is qualitatively different from the prior claims on the issue of whether the Claimant has pneumoconiosis.

The existence of pneumoconiosis may be established by chest x-rays classified as Category 1, 2, 3, A, B, or C according to ILO-U/C International Classification of Radiographs. Small opacities (1, 2, or 3) (in ascending order of profusion) may be classified as round (p, q, r) or irregular (s, t, u), and may be evidence of "simple pneumoconiosis." Large opacities (greater than 1 cm) may be classified as A, B, or C, in ascending order of size, and may be evidence of "complicated pneumoconiosis." A chest x-ray classified as category "0," including subcategories 0/-, 0/0, 0/1, does not constitute evidence of pneumoconiosis. 20 CFR § 718.102(b) (2005). Any such readings are, therefore, included in the "negative" column. X-ray interpretations which make no reference to pneumoconiosis, positive or negative, given in connection with medical treatment or review of an x-ray film solely to determine its quality, are listed in the "silent" column.

Physicians' qualifications appear after their names. Qualifications have been obtained where shown in the record by curriculum vitae or other representations, or if not in the record, by judicial notice of the lists of readers issued by the National Institute of Occupational Safety and Health (NIOSH), and/or the registry of physicians' specialties maintained by the American Board of Medical Specialties.[2] If no qualifications are noted for any of the following physicians, it means that either they have no special qualifications for reading x-rays, or I have been unable to ascertain their qualifications from the record, the NIOSH lists, or the Board of Medical Specialties. Qualifications of physicians are abbreviated as follows: A=NIOSH certified A reader; and, B=NIOSH certified B reader; BCR=Board certified in Radiology. Readers who are Board-certified Radiologists and/or B readers are classified as the most qualified. See *Mullins Coal Co. v. Director, OWCP*, 484 U.S. 135, 145 n. 16 (1987); *Old Ben Coal Co. v. Battram*, 7 F.3d 1273, 1276 n.2 (7th Cir. 1993). B readers need not be radiologists.

Date of X-ray	Read as Positive for Pneumoconiosis	Read as Negative for Pneumoconiosis	Silent as to the Presence of Pneumoconiosis
05/09/02	DX 15 Ahmed BCR, B 1/1	DX 18 Wheeler BCR, B	
08/23/02	DX 12 Baker B 1/0 DX 17 Pathak BCR,[3] B 1/1	DX 13 Wheeler BCR, B	DX 12 Goldstein B Read for quality only. Quality 1.
04/30/03	DX 17 Ahmed BCR, B 1/1	DX 14 Dahhan B DX 16 Wheeler BCR, B	

[2]NIOSH is the Federal Government Agency that certifies physicians for their knowledge of diagnosing pneumoconiosis by means of chest x-rays. Physicians are designated as "A" readers after completing a course in the interpretation of x-rays for pneumoconiosis. Physicians are designated as "B" readers after they have demonstrated expertise in interpreting x-rays for the existence of pneumoconiosis by passing an examination. Historical information about physician qualifications appears on the U.S. Department of Health and Human Services, Comprehensive List of NIOSH Approved A and B Readers, August 29, 2005, found at http://www.oalj.dol.gov/PUBLIC/BLACK_LUNG/REFERENCES/REFERENCE_WORKS/BREAD3_08_05.HTM. Current information about physician qualifications appears on the CDC/NIOSH, NIOSH Certified B Readers List found at http://www.cdc.gov/niosh/topics/chestradiography/breader-list.html. Information about physician board certifications appears on the website of the American Board of Medical Specialties, found at http://www.abms.org.

[3] Board certified in the United Kingdom. DX 15. I find this certification to be equivalent to certification in the United States. *See Hendrix v. Jim Walter Resources, Inc.*, BRB No. 99-1332 BLA, note 1 (Nov. 30, 2000) (unpub.).

Date of X-ray	Read as Positive for Pneumoconiosis	Read as Negative for Pneumoconiosis	Silent as to the Presence of Pneumoconiosis
05/13/03	DX 15 Pathak BCR, B 1/1	EX 1 Wheeler BCR, B	

X-ray interpretations from the prior claims appear on the following chart:

Date of X-ray	Read as Positive for Pneumoconiosis	Read as Negative for Pneumoconiosis	Silent as to the Presence of Pneumoconiosis
07/20/79		DX 2 Sargent BCR, B	
03/18/85		DX 2 Sargent BCR, B	
01/06/93		DX 2 Sargent BCR, B	
04/12/94		DX 1 Sargent BCR, B DX 1 Parrish	
05/09/94		DX 2 Sargent BCR, B	
05/16/95		DX 2 Sargent BCR, B	
09/22/97		DX 2 Sargent BCR, B	DX 2 Rouse (Lungs free of active infiltrates.)
12/04/97			DX 2 Cox (Stable post-operative appearance. May be some minimal right-sided basilar atelectasis.)
12/05/97			DX 2 Lynch (Lungs clear.)
12/30/97		DX 2 Sargent BCR, B	

Pulmonary Function Studies

Pulmonary function studies are tests performed to measure obstruction in the airways of the lungs and the degree of impairment of pulmonary function. The greater the resistance to the flow of air, the more severe the lung impairment. Tests most often relied upon to establish disability in black lung claims measure forced vital capacity (FVC), forced expiratory volume in one-second (FEV_1), and maximum voluntary ventilation (MVV).

The following chart summarizes the results of the pulmonary function studies available in connection with the current claim. "Pre" and "post" refer to administration of bronchodilators. If only one figure appears, bronchodilators were not administered. In a "qualifying" pulmonary study, the FEV_1 must be equal to or less than the applicable values set forth in the tables in Appendix B of Part 718, and either the FVC or MVV must be equal to or less than the applicable table value, or the FEV_1/FVC ratio must be 55% or less. 20 CFR § 718.204(b)(2)(i) (2005).

Ex. No. Date Physician	Age/ Height[4]	FEV_1 Pre-/ Post	FVC Pre-/ Post	FEV_1/ FVC Pre-/ Post	MVV Pre-/ Post	Qualify?	Physician Impression
04/12/94 DX 15, DX 1 Parrish	48/ 71"	3.47	4.16	83.4%	99	No	
05/09/02 DX 15 Narayanan	56/ 71"	2.02	2.91	69.4%	64.0	Yes	Moderate restriction. Invalid per Dr. Dahhan, EX 3.
08/23/02 DX 12 Baker	57/ 69.5"	2.67	3.88	69%		No	Mild obstructive defect. Questioned maximum effort
04/16/03 DX 15 Bruton	57/ 71"	1.95	2.40	81%		Yes	Mild restrictive defect.
04/30/03 DX 14 Dahhan	57/ 182 cm (71.7")	2.89 2.46	3.63 3.06	80% 81%	84.0 94.0	No No	Poor cooperation.
11/01/04 EX 2 Hudson	59/ 71"	3.34	4.55	73%		No	

The only pulmonary function study taken in connection with the prior claims was also in the record of the current claim, and appears on the chart above.

Arterial Blood Gas Studies

Blood gas studies are performed to measure the ability of the lungs to oxygenate blood. A defect will manifest itself primarily as a fall in arterial oxygen tension either at rest or during exercise. The blood sample is analyzed for the percentage of oxygen (pO_2) and the percentage of carbon dioxide (pCO_2) in the blood. A lower level of oxygen (O_2) compared to carbon dioxide (CO_2) in the blood indicates a deficiency in the transfer of gases through the alveoli which may leave the miner disabled.

The following chart summarizes the arterial blood gas studies available in connection with the current claim. A "qualifying" arterial gas study yields values which are equal to or less than the applicable values set forth in the tables in Appendix C of Part 718. If the results of a blood gas test at rest do not satisfy Appendix C, then an exercise blood gas test can be offered.

[4] The fact-finder must resolve conflicting heights of the miner recorded on the ventilatory study reports in the claim. *Protopappas v. Director, OWCP*, 6 B.L.R. 1-221, 1-223 (1983); *Toler v. Eastern Assoc. Coal Co.*, 43 F.3d 109, 114, 116 (4th Cir. 1995). As there is a variance in the recorded height of the Miner from 69.5" to 71.7" I have taken the mid-point (70.6") in determining whether the studies qualify to show disability under the regulations.

Tests with only one figure represent studies at rest only. Exercise studies are not required if medically contraindicated. 20 CFR § 718.105(b) (2005). No exercise studies were performed in connection with the current claim.

Exhibit Number	Date	Physician	pCO_2 at rest/ exercise	pO_2 at rest/ exercise	Qualify?	Physician Impression
DX 12	08/23/02	Baker	44	77	No	Mild resting hypoxemia.
DX 14	04/30/03	Dahhan	41	81	No	
EX 2	11/01/04	Hudson	42	73	No	

The following chart summarizes the arterial blood gas studies available in connection with the prior claims.

Exhibit Number	Date	Physician	pCO_2 at rest/ exercise	pO_2 at rest/ exercise	Qualify?	Physician Impression
DX 1	04/12/94	Parrish	38.5 41.4	86.0 89.4	No No	
DX 2	12/04/97	Pietrasz	49.0	230.6	No	Taken during hospitalization for heart surgery
DX 2	12/04/97	Pietrasz	42.0	80.8	No	Taken during hospitalization for heart surgery

Medical Opinions

Medical opinions are relevant to the issues of whether the miner has pneumoconiosis, whether the miner is totally disabled, and whether pneumoconiosis caused the miner's disability. A determination of the existence of pneumoconiosis may be made if a physician, exercising sound medical judgment, notwithstanding a negative x-ray, finds that the miner suffers from pneumoconiosis as defined in § 718.201. 20 CFR §§ 718.202(a)(4) (2005). Thus, even if the x-ray evidence is negative, medical opinions may establish the existence of pneumoconiosis. *Taylor v. Director, OWCP*, 9 B.L.R. 1-22 (1986). The medical opinions must be reasoned and supported by objective medical evidence such as blood gas studies, electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories. 20 CFR § 718.202(a)(4) (2005). Where total disability cannot be established by pulmonary function tests, arterial blood gas studies, or cor pulmonale with right-sided heart failure, or where pulmonary function tests and/or blood gas studies are medically contra-indicated, total disability may be nevertheless found, if a physician, exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in employment, *i.e.*, performing his usual coal mine work or comparable and gainful work. 20 CFR § 718.204(b)(2)(iv) (2005). With certain specified exceptions not applicable here, the cause or causes of total disability must be established by means of a

physician's documented and reasoned report. 20 CFR § 718.204(c)(2) (2005). The record contains the following medical opinions submitted in connection with the current claim.

The record contains operative notes from Methodist Medical Center dated December 4, 1997, completed by Dr. William Hall. CX 4; s*ee also,* DX 2 from prior claim. The Claimant underwent an aortic valve replacement. Lungs were hyperinflated with air trapping and chronic obstructive pulmonary disease ("COPD"), "although he had good blood gases, saturation, and CO2 exchange."

The record contains office notes completed by Kellie Brooks, a Family Nurse Practitioner, dated June 3, 2002, from Stone Mountain Health Services. CX 1. Ms. Brooks notes 17 years of coal mine employment and a past history of COPD and coal workers' pneumoconiosis, with current symptoms of cough, wheezing, orthopnea, and shortness of breath with exertion. X-rays were sent for reading by a B reader.

Dr. Glen Baker, a Board-certified Internist, Pulmonologist, and B reader, examined the Claimant on behalf of the Department of Labor on August 23, 2002. DX 12. Based on symptomatology (sputum, cough, dyspnea, wheeze, hemoptysis, chest pain, orthopnea), employment history (20 years coal mine employment), individual and family histories (aortic valve replacement), smoking history (nonsmoker), physical examination (normal), chest x-ray (1/0), pulmonary function study (mild obstruction), arterial blood gas study (mild resting hypoxemia), and an EKG (normal), Dr. Baker diagnosed coal workers' pneumoconiosis, based on a history of coal dust exposure and a positive x-ray; chronic bronchitis, based on a history of cough, sputum, and wheezing; COPD, based on pulmonary function testing; hypoxemia, based on arterial blood gas readings; and, a history of aortic valve replacement. He listed the etiology of all conditions except the aortic valve replacement as coal dust exposure. He opined that the Miner suffered from a mild impairment, based on pulmonary function and arterial blood gas testing, and that he retained the respiratory capacity to perform the work of a coal miner or comparable work in a dust-free environment.

Dr. Charles W. Bruton examined the Claimant on April 16, 2003. DX 15. According to the American Board of Medical Specialties website, Dr. Bruton is Board-certified in Internal Medicine and Pulmonology. Based on symptomatology (wheeze), employment history (18 years coal mine employment), individual and family histories (aortic valve replacement), smoking history (nonsmoker), physical examination (rales, few scattered wheezes), chest x-ray (1/1), and pulmonary function study (mild obstruction), Dr. Bruton diagnosed coal workers' pneumoconiosis. He based his opinion on positive x-ray evidence, history of coal exposure, nonsmoking status of the Claimant, physical examination, pulmonary function readings and emphysematous changes in a nonsmoking environment. Dr. Bruton did not offer an opinion as to pulmonary disability.

Dr. Richard Hudson, Jr., a Board-certified Internist, Pulmonologist, and B reader, examined the Claimant on behalf of the Employer on November 1, 2004 (EX 2). Based on symptomatology (short of breath, cough, sputum, hemoptysis), employment history (17-18 years coal mine employment), individual and family histories (aortic valve replacement; hypertension), smoking history (nonsmoker), physical examination (good breath sounds, faint intermittent bilateral exp. wheezes), chest x-ray (1/0), pulmonary function study (normal), and arterial blood gas study (normal), Dr. Hudson diagnosed industrial bronchitis due to coal dust; x-ray evidence

of pneumoconiosis with no significant pulmonary impairment; and, history of aortic valve replacement and spontaneous pneumothorax. He based his diagnosis on physical examination, x-ray, history of exposure, and Claimant's nonsmoking status. Dr. Hudson questioned whether x-ray evidence demonstrated the existence of pneumoconiosis. Specifically, he stated that:

> This patient has an adequate mining exposure to cause coal workers' pneumoconiosis coupled with chest x-ray changes that are borderline for coal workers' pneumoconiosis. However, the chest x-ray changes are located in the lower lungs, whereas typically in coal workers' pneumoconiosis they are present in the upper lung zones. Also, one wonders what influence his previous valvular heart disease may have had on his lungs, such as causing some interstitial pulmonary edema for a while prior to his aortic valve replacement….

Dr. Bruton performed a follow-up examination on February 1, 2005. CX 3. At that time, lungs were clear. Pulmonary function testing revealed FVC of 43% of predicted and FEV_1 of 44% of predicted. He opined that AMA Guidelines suggest that the patient had a class 4 impairment, which is 51-100% whole person impairment. He opined that the patient was permanently and totally disabled due to coal workers' pneumoconiosis.

Ms. Brooks submitted additional notes dated February 14, 2005. CX 5. Claimant complained of cough and sputum, orthopnea, and shortness of breath. Ms. Brooks made an assessment of coal workers' pneumoconiosis and COPD.

Dr. A. Dahhan, a Board-certified Internist, Pulmonologist, and B reader, performed a records review at the request of the Employer, and prepared a report dated February 21, 2005. EX 3. He reviewed spirometry reports dated November 1, 2004, and May 9, 2002, a medical report by Dr. Hudson (EX 2), nurse's notes from Stone Mountain Health Services (CX 5), and a medical report by Dr. Glen Baker (DX 12). In review, Dr. Dahhan diagnosed simple coal workers' pneumoconiosis based on positive x-ray evidence and medical examinations. He opined that valid objective testing showed no evidence of functional pulmonary impairment and/or disability. He opined that normal pulmonary function and arterial blood gas readings show that the Claimant retained the capacity to continue his previous coal mine employment.

Additional treatment records were submitted in connection with the prior claim. DX 2. Dr. Daniel Lenoir saw the Claimant in September and October 1997. The Claimant reported shortness of breath, particularly on exertion, worsening over several months. Dr. Lenoir diagnosed bronchitis, a heart murmur, and atypical chest pain with an abnormal EKG, and scheduled an echocardiogram. Dr. Lech K. Pietrasz, examined the Claimant on several occasions for heart-related problems. DX 2. According to the American Board of Medical Specialties, Dr. Pietrasz is Board-certified in Internal Medicine and Cardiovascular Disease. He noted moderately severe heart-related conditions, and reported that the lungs were clear to auscultation. He performed a heart valve replacement on the Claimant. Dr. Pietrasz did not make any diagnosis regarding pneumoconiosis, or give an opinion as to whether the Claimant was disabled. Records of the Claimant's hospitalization for chest pain in 1991 and 1995, and 1997 valve replacement surgery, are also contained in DX 2. A 1995 CT scan revealed no pulmonary nodules.

Dr. Richard E. Parrish examined the Claimant on behalf of the Department of Labor on April 12, 1994, in connection with his first claim. DX 1. According to the American Board of Medical Specialties, Dr. Parrish is Board-certified in Internal Medicine, Critical Care Medicine, and Pulmonary Disease. He noted 17 years of coal mine employment, a history of heart-related conditions, the Claimant's nonsmoking status, and symptoms of sputum, wheezing, cough, dyspnea, hemoptysis, chest pain, orthopnea, and ankle edema. Examination of the chest was normal, x-ray evidence was negative for pneumoconiosis, and pulmonary function and arterial blood gases were normal. He diagnosed only heart-related abnormalities and he stated that the Miner suffered from no pulmonary or respiratory impairment based on the testing performed.

There is no report of a Department of Labor-sponsored examination conducted in connection with the second claim.

Existence of Pneumoconiosis

The regulations define pneumoconiosis broadly:

> (a) For the purpose of the Act, 'pneumoconiosis' means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or 'clinical,' pneumoconiosis and statutory, or 'legal,' pneumoconiosis.
>
> (1) Clinical Pneumoconiosis. 'Clinical pneumoconiosis' consists of those diseases recognized by the medical community as pneumoconioses, i.e., the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silico-tuberculosis, arising out of coal mine employment.
>
> (2) Legal Pneumoconiosis. 'Legal pneumoconiosis' includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.
>
> (b) For purposes of this section, a disease 'arising out of coal mine employment' includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.
>
> (c) For purposes of this definition, 'pneumoconiosis' is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.

20 CFR § 718.201 (2005).

Twenty CFR § 718.202(a) (2005) provides that a finding of the existence of pneumoconiosis may be based on: (1) chest x-ray; (2) biopsy or autopsy; (3) application of the presumptions described in §§ 718.304 (irrebuttable presumption of total disability due to pneumoconiosis if there is a showing of complicated pneumoconiosis), 718.305 (not applicable to claims filed after January 1, 1982), or 718.306 (applicable only to deceased miners); or, (4) a physician exercising sound medical judgment based on objective medical evidence and supported by a reasoned medical opinion. There is no evidence that the Claimant has had a lung biopsy and, of course, no autopsy has been performed. None of the presumptions apply, because the evidence does not establish the existence of complicated pneumoconiosis, the Claimant filed his claim after January 1, 1982, and he is still living. In order to determine whether the evidence establishes the existence of pneumoconiosis, therefore, I must consider the chest x-rays and medical opinions. As this claim is governed by the law of the Sixth Circuit, the Claimant may establish the existence of pneumoconiosis under any one of the alternate methods set forth at § 202(a). *See Cornett v. Benham Coal Co.*, 227 F.3d 569, 575 (6th Cir. 2000); *Furgerson v. Jericol Mining, Inc.*, 22 B.L.R. 1-216 (2002) (*en banc*).

Pneumoconiosis is a progressive and irreversible disease. *Labelle Processing Co. v. Swarrow*, 72 F.3d 308, 314-315 (3rd Cir. 1995); *Lane Hollow Coal Co. v. Director, OWCP*, 137 F.3d 799, 803 (4th Cir. 1998); *Woodward v. Director, OWCP*, 991 F.2d 314, 320 (6th Cir. 1993). As a general rule, therefore, more weight is given to the most recent evidence. *See Mullins Coal Co. of Virginia v. Director, OWCP*, 484 U.S. 135, 151-152 (1987); *Eastern Associated Coal Corp. v. Director, OWCP*, 220 F.3d 250, 258-259 (4th Cir. 2000); *Crace v. Kentland-Elkhorn Coal Corp*., 109 F.3d 1163, 1167 (6th Cir. 1997); *Rochester & Pittsburgh Coal Co. v. Krecota*, 868 F.2d 600, 602 (3rd Cir. 1989); *Stanford v. Director, OWCP*, 7 B.L.R. 1-541, 1-543 (1984); *Tokarcik v. Consolidated Coal Co*., 6 B.L.R. 1-666, 1-668 (1983); *Call v. Director, OWCP*, 2 B.L.R. 1-146, 1-148-1-149 (1979). This rule is not to be mechanically applied to require that later evidence be accepted over earlier evidence. *Woodward*, 991 F.2d at 319-320; *Adkins v. Director, OWCP*, 958 F.2d 49 (4th Cir. 1992); *Burns v. Director, OWCP*, 7 B.L.R. 1-597, 1-600 (1984).

Of the available x-rays filed in connection with the current claim, all four have been read as both positive and negative. For cases with conflicting x-ray evidence, the regulations specifically provide,

> … where two or more X-ray reports are in conflict, in evaluating such X-ray reports consideration shall be given to the radiological qualifications of the physicians interpreting such X-rays.

Twenty CFR § 718.202(a)(1) (2005); *Dixon v. North Camp Coal Co*., 8 B.L.R. 1-344 (1985); *Melnick v. Consolidation Coal Co*., 16 B.L.R. 1-31, 1-37 (1991). Readers who are Board-certified Radiologists and/or B-readers are classified as the most qualified. The qualifications of a certified Radiologist are at least comparable to if not superior to a physician certified as a B reader. *Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211, 1-213 n.5 (1985). Greater weight may be accorded to x-ray interpretations of dually qualified physicians. *Sheckler v. Clinchfield Coal Co*., 7 B.L.R. 1-128, 1-131 (1984). A Judge may consider the number of interpretations on each side of the issue, but not to the exclusion of a qualitative evaluation of the x-rays and their readers. *Woodward*, 991 F.2d at 321; *see Adkins*, 958 F.2d at 52.

The May 9, 2002, x-ray was read as negative by Dr. Wheeler, a Board-certified Radiologist and B reader, and as positive by Dr. Ahmed, a Board-certified Radiologist and B reader. Noting equal qualifications and conflicting interpretations, I find that the May 9, 2002, x-ray evidence is inconclusive for pneumoconiosis.

The August 23, 2002, x-ray was read as negative by Dr. Wheeler, a Board-certified Radiologist and B reader, as positive by Dr. Pathak, a Board-certified Radiologist and B reader, and as positive by Dr. Baker, a B reader. I give greater weight to the two positive readings over the sole negative interpretation and find that the August 23, 2002, x-ray evidence is positive for pneumoconiosis.

The April 30, 2003, x-ray was read as negative by Dr. Wheeler, a Board-certified Radiologist and B reader, as negative by Dr. Dahhan, a B reader, and as positive by Dr. Ahmed, a Board-certified Radiologist and B reader. I give greater weight to the two negative readings over the one positive reading and find that the April 30, 2003, x-ray evidence is negative for pneumoconiosis.

Finally, the May 13, 2003, x-ray was read as negative by Dr. Wheeler, a Board-certified Radiologist and B reader, and as positive by Dr. Pathak, who is also dually certified. As the qualifications are equal and the interpretations opposite, I find that the May 13, 2003, x-ray evidence is inconclusive for pneumoconiosis.

The record of the current claim contains one positive film, one negative film, and two films in equipoise. In review of qualifications, there are eight interpretations made by Board-certified Radiologists and B readers. Four are positive and four are negative. There are two interpretations by B readers, one positive and one negative. There are a total of five negative and five positive readings. The Claimant is required to prove each element of entitlement by a preponderance of the evidence. While there is evidence in the record to support the Miner's claim, the newly submitted x-ray evidence of record does not prove the existence of pneumoconiosis by a preponderance of the evidence. I find that the existence of pneumoconiosis has not been established in the current claim pursuant to 20 C.F.R. § 718.202(a)(1). All of the x-ray readings in the prior claims were negative; however, they are of x-rays taken remotely in time, and are entitled to less weight. Considering all of the x-ray evidence together does not change my conclusion regarding the x-ray evidence.

I must next consider the medical opinions. The Claimant can establish that he suffers from pneumoconiosis by well-reasoned, well-documented medical reports. A "documented" opinion is one that sets forth the clinical findings, observations, facts, and other data upon which the physician based the diagnosis. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-22 (1987). An opinion may be adequately documented if it is based on items such as a physical examination, symptoms, and the patient's work and social histories. *Hoffman v. B&G Construction Co*., 8 B.L.R. 1-65, 1-66 (1985); *Hess v. Clinchfield Coal Co*., 7 B.L.R. 1-295, 1-296 (1984); *Justus v. Director, OWCP*, 6 B.L.R. 1-1127, 1-1129 (1984). A "reasoned" opinion is one in which the Judge finds the underlying documentation and data adequate to support the physician's conclusions. *Fields*, above. Whether a medical report is sufficiently documented and reasoned is for the Judge to decide as the finder-of-fact; an unreasoned or undocumented opinion may be given little or no weight. *Clark v. Karst-Robbins Coal Co*., 12 B.L.R. 1-149, 1-155 (1989) (*en banc*).

In this case, setting aside the notes of the Claimant's heart surgeon, Dr. Hall, who did not explain the basis for his pulmonary diagnoses, I find that all of the medical opinions in the current claim are reasoned and documented. Despite the conflict in the x-ray evidence which renders it inconclusive, all of the physicians who offered an opinion (Dr. Baker, Dr. Bruton, Dr. Hudson, and Dr. Dahhan) diagnosed coal workers' pneumoconiosis or other coal dust-induced disease (COPD, emphysema, or bronchitis), as did the nurse practitioner, whose opinion, of course, is entitled to less weight than those of the physicians. Taken as a whole, Drs. Baker, Bruton, Hudson, and Dahhan, all well-qualified Pulmonary Specialists, provide well-reasoned opinions, based upon objective medical evidence, that Claimant suffers from pneumoconiosis as defined in 20 CFR § 718.201.

The Miner's previous claim was denied on January 30, 1998. The newly submitted medical reports rely on a qualitatively different medical record generated since the prior denial. Accordingly, I find that the Claimant has established the existence of pneumoconiosis under 20 CFR § 718.202(a)(4) through newly submitted evidence. As such, he has demonstrated a material change in conditions as required by 20 CFR § 725.309. Dr. Parrish's contrary opinion in 1994 does not undermine the finding of pneumoconiosis, as it was remote in time, and Dr. Parrish simply did not have available the evidence relied upon by the doctors who are now of the opinion that the Claimant suffers from coal dust-induced disease.

Causal Relationship Between Pneumoconiosis and Coal Mine Employment

The Act and the regulations provide for a rebuttable presumption that pneumoconiosis arose out of coal mine employment if a miner with pneumoconiosis was employed in the mines for 10 or more years. 30 U.S.C. § 921(c)(1); 20 CFR § 718.203(b) (2005). The Claimant was employed as a miner for at least 17 years and, therefore, is entitled to the presumption. The Employer has not offered any evidence to rebut the presumption. Moreover, to the extent that the Claimant has legal, as opposed to clinical pneumoconiosis, the causal relationship is established by the opinions of the doctors. I conclude that the Claimant's pneumoconiosis was caused by his coal mine employment.

Total Pulmonary or Respiratory Disability

A miner is considered totally disabled if he has complicated pneumoconiosis, 30 U.S.C. § 921(c)(3), 20 CFR § 718.304 (2005), or if he has a pulmonary or respiratory impairment to which pneumoconiosis is a substantially contributing cause, and which prevents him from doing his usual coal mine employment and comparable gainful employment, 30 U.S.C. § 902(f), 20 CFR § 718.204(b) and (c) (2005). The regulations provide five methods to show total disability other than by the presence of complicated pneumoconiosis: (1) pulmonary function studies; (2) blood gas studies; (3) evidence of cor pulmonale; (4) reasoned medical opinion; and, (5) lay testimony. 20 CFR § 718.204(b) and (d) (2005). Lay testimony may only be used in establishing total disability in cases involving deceased miners, and in a living miner's claim, a finding of total disability due to pneumoconiosis cannot be made solely on the miner's statements or testimony. 20 CFR § 718.204(d) (2005); *Tedesco v. Director, OWCP*, 18 B.L.R. 1-103, 1-106 (1994). There is no evidence in the record that the Claimant suffers from complicated pneumoconiosis or cor pulmonale. Thus, I will consider pulmonary function studies, blood gas studies, and medical opinions. In the absence of contrary probative evidence,

evidence from any of these categories may establish disability. If there is contrary evidence, however, I must weigh all the evidence in reaching a determination whether disability has been established. 20 CFR § 718.204(b)(2) (2005); *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-21 (1987); *Shedlock v. Bethlehem Mines Corp.*, 9 B.L.R. 1-195, 1-198 (1986).

I must determine the reliability of a study based upon its conformity to the applicable quality standards, *Robinette v. Director, OWCP*, 9 B.L.R. 1-154 (1986), and must consider medical opinions of record regarding reliability of a particular study. *Casella v. Kaiser Steel Corp*., 9 B.L.R. 1-131, 1-133–134 (1986). Little or no weight may be accorded to a ventilatory study if the miner exhibited "poor" cooperation or comprehension. *Houchin v. Old Ben Coal Co*., 6 B.L.R. 1-1141 (1984); *Runco v. Director, OWCP*, 6 B.L.R. 1-945, 1-946–947 (1984); *Justice v. Jewell Ridge Coal Co*., 3 B.L.R. 1-547, 1-551 (1981). In *Crapp v. U.S. Steel Corp*., 6 B.L.R. 1-476 (1983), however, the Board held that a nonconforming pulmonary function test may be entitled to probative value where the results exceed the table values, *i.e.*, the test is non-qualifying. As the Board noted, "[d]espite any deficiency in cooperation and comprehension, the demonstrated ventilatory capacity was still above the table values. Had the claimant understood or cooperated more fully, the test results could only have been higher." 6 B.L.R. at 1-479.

Of the six tests of record, the May 9, 2002, test was found to be invalid by Dr. Dahhan. Of the remaining five, only the April 6, 2003, test produced qualifying readings. The two prior tests and the two subsequent tests produced nonqualifying numbers despite any deficiencies listed in effort or comprehension. I find that the pulmonary function testing of record does not establish total disability.

Total disability may be found under 20 CFR § 718.204(b)(2)(ii) if there are arterial blood gas studies with results equal to or less than those contained in the tables. The record contains six arterial blood gas studies. All arterial blood gas testing results are nonqualifying.

Under 20 CFR § 718.204(b)(2)(iv), total disability may be found if a physician exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevented the miner from engaging in his usual coal mine work or comparable and gainful work.

The opinion of Dr. Pietrasz, along with the office notes of Kellie Brooks and the records from Methodist Medical Center, do not offer an opinion on the issue of total disability. A physician's report that is silent as to a particular issue is not probative of that issue. *Island Creek Coal Co. v. Compton*, 211 F.3d 203 (4th Cir. 2000).

Dr. Dahhan diagnosed no functional disability or impairment based on pulmonary function testing and arterial blood gas testing. Dr. Dahhan's opinion is based on objective testing and he documents which readings support his findings. Noting Dr. Dahhan's superior credentials, I give his opinion substantial weight.

Dr. Hudson diagnosed no significant pulmonary impairment, based on physical examination, pulmonary function testing, and arterial blood gas testing. His opinion is based on objective testing, and he documents which readings support his finding. I find his report well reasoned and I afford his disability diagnosis substantial weight.

Dr. Baker opined that the Miner suffers from a mild impairment and that he retains the respiratory capacity to return to his previous coal mine employment. He based his opinion on pulmonary function testing and arterial blood gas testing. His opinion is well reasoned and based on objective data. I also give Dr. Baker's opinion on disability substantial weight.

Dr. Parrish examined the Claimant in 1994 as part of the evidence submitted in the Claimant's first claim for benefits. He diagnosed no pulmonary or respiratory impairment based on normal pulmonary function and arterial blood gas testing. Although Dr. Parrish based his opinion on objective testing, his examination of the Claimant is almost 12 years old. I give this older evidence little weight due to the age of the data used.

Only Dr. Bruton opined that the Claimant is totally disabled. He said that the Claimant's pulmonary function test suggests that he has a Class 4 impairment, and that such a condition would render the Claimant totally disabled due to coal workers' pneumoconiosis. Dr. Bruton's opinion, however, was based on the only qualifying pulmonary function test. On two later tests, the results were not only nonqualifying, but greatly exceeded qualifying values. Weighing his opinion against those of Drs. Dahhan, Hudson and Baker, I find that the Claimant has failed to show by a preponderance of the evidence that he is totally disabled.

As a result of predominately nonqualifying pulmonary testing, nonqualifying blood gas testing, and the well-reasoned opinions of Drs. Dahhan, Hudson, and Baker, that the Claimant does not suffer from total pulmonary or respiratory disability, I find that the evidence fails to establish total disability under 20 CFR § 718.204(b)(2).

FINDINGS AND CONCLUSIONS REGARDING ENTITLEMENT TO BENEFITS

Because the Claimant has failed to meet his burden to establish that he is totally disabled due to pneumoconiosis, he is not entitled to benefits under the Act.

ATTORNEY FEES

The award of an attorney's fee under the Act is permitted only in cases in which the claimant is found to be entitled to benefits. Section 28 of the Longshore and Harbor Workers' Compensation Act, 33 U.S.C. § 928, as incorporated into the Black Lung Benefits Act, 30 U.S.C. § 932. Since benefits are not awarded in this case, the Act prohibits the charging of any fee to the Claimant for services rendered to him in pursuit of this claim.

ORDER

The claim for benefits for modification filed by the Claimant on June 17, 2002, is hereby DENIED.

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ALICE M. CRAFT
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the Administrative Law Judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the Administrative Law Judge's decision is filed with the District Director's office. *See* 20 C.F.R. §§ 725.478 and 725.479. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, D.C., 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, D.C., 20210. *See* 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the Administrative Law Judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).